EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY OR DISEASE (DWC-01)

By law, the employer must complete a First Report of Injury for an employee for any work-related injury, if that injury requires any medical treatment or if the employee loses full wages for at least three (3) days. The employer must also report any work-related death.

General Instructions:

- Please clearly print or type information into all of the areas of the First Report – FORMS MAY BE REJECTED IF INCOMPLETE.
- Completed by: Employer.
- Time Frame: Within 10 days of knowledge of the injury OR within 48 hours of death. If you do not send in the First Report on time **or** if it is incomplete, you may be subject to a **$250 fine**.
- Distribution: Original to Department of Labor and Training (DLT)/address on form; Copy to Claim Administrator; Employer File Copy.
- Attachments: None. DO NOT ATTACH MEDICAL REPORTS.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. ***Employer Location:***
   - *FEIN:* Employer's Federal Employer Identification Number.
   - *Name:* Employer's actual name where the employee was employed at the time of the injury.
   - *Address (including city, state, zip):* Address of the employer's actual location.
   - *Phone/Ext:* Phone number and extension (if necessary) of the employer's facility.
   - *Type of Business:* General classification of what the business does on a daily basis. (Ex. Restaurant; Jewelry Manufacturing; etc.)
   - *RI Unemployment Ins. No.:* This number (ERN – Employer Record Number) is assigned to employers by the Rhode Island Division of Taxation and is used by employers when paying their RI Unemployment Insurance and Temporary Disability Insurance taxes. The Division of Worker's Compensation will use this number for employer identification purposes only.
   - *NAICS:* North American Industry Classification System, established by the US Census Bureau to provide common industry classifications based on the type of business. Visit www.census.gov and click on NAICS to locate the industry code. IF THIS CODE CANNOT BE OBTAINED, BE SURE TO HAVE COMPLETED 'Type of business' on the form.
2. ***Employer Named on WC Insurance Policy:*** If this information is identical to the information in Block 1, check the 'Same' box, complete the WC Policy information, and move onto Block 3. If different, proceed below.
   - *FEIN:* Federal Employer Identification Number of the employer listed on the WC Insurance Policy.
   - *Name:* Insured named on the policy or the financially responsible self-insured employer, as certified by DLT.
   - *Address (including city, state, zip):* Mailing address of the employer named on the WC Insurance Policy.
   - *Phone/Ext:* Phone number and extension (if necessary) of the named employer's facility.
   - *WC Policy Number:* Number assigned to the WC contract or policy for that employer.
3. ***Insurance company named on WC Policy:***
   - *FEIN:* WC Insurance company's Federal Employer Identification Number.
   - *Name:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
   - *Address (including city, state, zip):* Mailing address of the WC insurance carrier named on the WC Insurance Policy.
   - *Phone/Ext:* Phone number and extension (if necessary) of the named WC insurance carrier.
4. ***Claim Administrator****:* If this information is identical to the information in Block 3, check the 'Same' box, and move onto Block 5. If different, proceed below.
   - *FEIN:* Federal Employer Identification Number of the company administering the claim.
   - *Name:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
   - *Address (including city, state, zip):* Mailing address of the claim administrator.
   - *Phone/Ext:* Phone number and extension (if necessary) of the claim administrator.
5. ***Employee:***
   - *SSN:* Employee's Social Security Number.
   - *Male/Female:* Check one.
   - *Name:* Employee's full name as shown on payroll.
   - *Address (including city, state, zip):* Employee's current mailing address.
   - *Phone:* Employee's current home telephone number.
   - *Date of Birth:* Date the employee was born.
   - *Occupation:* Primary occupation of the employee at the time of the accident.
   - *Date Hired:* Date the employee began his or her employment with the employer.
   - *State of Hire:* State in which the employee was actually hired.
   - *Preferred Language of Employee:* Primary language spoken or understood by the employee.
6. ***Medical Information:***
   - *Treatment Facility:* Name of the facility where employee received treatment for injury or illness.
   - *Address (including city, state, zip):* Treatment facility address.
   - *Phone/Ext:* Phone number and extension (if necessary) of the treatment facility.
7. ***Witness Information:***
   - *Name:* Name of person or persons who witnessed injury.
   - *Phone:* Phone number (s) or witness(es)

8. Injury Information:

- *Injury Date:* Date that the accident happened.
- *Time injury occurred:* Time that the injury happened.
- *Time employee began work:* Time that the employee began work on the day the injury happened.
- *First full day lost from work:* First full day that the employee lost from work (include weekends and holidays). This is referred to as the Incapacity Date throughout the claim OR check *NONE LOST* if the employee lost no time due to the injury.
- *Date returned to work (if appropriate):* If employee has returned to work, complete this question.
- *Date employer notified of injury:* Date that the injury was reported to a representative of the employer.
- *If fatal, REPORT WITHIN 48 HOURS – Date of Death:* Conditional, if employee died.
- *What was person doing when injured:* A brief description of how the accident happened.
- *List injured body parts and nature of injury:* Detailed description of what part or parts were injured and what type of injury it is.
- *Place where injury/illness occurred:* Check box if the injury happened at the address of the employer listed in Block 1 OR enter the complete address (including city and state) where injury actually took place.
- *Was this injury previously an incident-only with no medical treatment and no time lost?:* Check *No* if that is the appropriate answer. Checking *Yes* refers to injuries which were originally not reportable to the State—meaning that the employee lost no time or received no medical treatment for their injury (incident only). If the injury later becomes reportable because the employee now has **either** lost full wages for at least three (3) days **or** received any medical treatment due to the work-related injury, then check Yes.
- *If Yes, date employer first notified of medical treatment or time lost:* If *Yes* was checked, enter appropriate date.
- *Category(ies) of injury or illness:* Check the appropriate item(s).

- *Print Name of Report Preparer/Date Prepared/Phone & Extension:* Clearly enter the name of the person who filled out the form, the date that the form was prepared, and the complete phone number of the preparer.
- *Print Name of Employer Contact Person OR Same as above /Phone & Extension:* Check box if the information is identical or clearly enter the name and complete phone number of the employer's contact person.